STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155464	A. BUILDING 00 B. WING	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKVILLE NURSING AND REHABILITATION CENTER	768 NORTH US HIGHWAY 41 ROCKVILLE, IN47872

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F0000	This visit was for the Investigation of Complaint IN00089659. Complaint IN00089659 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F250, F272, F279, & F514. Survey dates: May 11 & 12, 2011 Facility number: 000492 Provider number: 155464 AIM number: 100291360 Survey team: Diane Dierks, RN Census bed type: SNF/NF: 37 Total: 37 Census payor type: Medicare: 4 Medicaid: 18 Other: 15 Total: 37 Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 5/18/11 by	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Jennie Bartelt, RN.			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to ensure the physician and	F0157	Preparation and/or execution of this plan does not constitute admission or agreement by the	06/11/2011

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	family were notified of a significant change in psychosocial status for 1 of 3 residents reviewed for behaviors in a sample of 5 (Resident D). Findings include: A facility policy, dated February, 2004, titled "Standards and Guidelines: Incident Reporting and Documentation," provided by the DON (Director of Nursing) on 5/11/11 at 3:45 p.m., included, but was not limited to, the following: "...An event/incident may be defined as: An unexpected occurrence not consistent with routine...care of the resident. This event/incident may or may not cause injury. Events/incidents may be related to resident ....or staff...2. Notify the attending physician and document in the medical record...3. Notify the family or responsible party." The clinical record review for Resident D was reviewed on 5/11/11 at 4:00 p.m. Diagnoses for Resident D included, but were not limited to, Alzheimer's disease, dementia with behavior, psychosis, delirium, anxiety, alcohol abuse, hypertension, arteriosclerotic vascular disease, chronic obstructive pulmonary disease, osteoarthritis, malaise and		provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 157 Notify of Changes (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: MD and Family (for resident “D”) were notified of this resident having displayed inappropriate sexual behavior. Resident “D” care plan was revised to include interventions for inappropriate sexual behavior. **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** A facility audit was conducted to identify current Residents that are experiencing inappropriate sexual behaviors. No other Residents were identified. . **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Licensed nursing staff was re educated regarding MD/Family notification of displayed inappropriate sexual behavior. Facility staff were re-educated on what actually is considered or represent displayed inappropriate sexual behavior, and the importance of notifying/reporting of displayed inappropriate sexual behavior activity so that this can	

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	fatigue, and difficulty walking. During an interview on 5/11/11 at 11:25 a.m., the DON indicated that incident reports were not completed when CNA's came to her with reports of Resident D's inappropriate sexual behavior. She stated, "I told them to put it on the Behavior Log - whether they did or not that's another story." During an interview on 5/11/11 at 4:05 p.m., the DON indicated that no investigation was done regarding the incident when Resident D grabbed CNA # 1 in a sexually inappropriate manner in the shower room. During an interview on 5/11/11 at 4:24 p.m., the DON indicated the incident of Resident D grabbing CNA # 1, in a sexually inappropriate manner in the shower room, was a new behavior and it was not, to the best of her knowledge, documented in the chart or the Behavior Log. She also indicated the physician was not notified. She indicated Resident D's behavior had always been directed at staff, not residents, and this was the first time it had become physical. During an interview with the SSD (Social Services Director) on 5/12/11 at 10:05 a.m., she indicated CNA # 1 had reported		be addressed by medical personal. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** DNS /Designee will review 24 hour report to identify any Resident with reported displayed inappropriate sexual behavior at the morning stand-up meeting. Any identified behaviors will result in review of Residents clinical record to assure documentation of MD/Family notification. Report of the audits will be presented to the Risk Management meeting to ensure compliance has been met and it is recommended that oversight monitoring will be quarterly by the RDCO when system review is completed which includes review of behavior management and MD/Family notification. **Date of compliance:** June 11, 2011	

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	to her that Resident D had grabbed her in the vaginal area while she was providing him shower care. The SSD indicated this was the first time that Resident D had displayed physically sexually inappropriate behavior. The SSD indicated she reported the occurrence to the DON and the Administrator, but she did not notify the physician or the family. This federal tag is related to Complaint IN00089659. 3.1-5(a)(2)			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review the facility failed to ensure that social services adequately addressed and planned care for the management of sexually inappropriate behavior for 1 of 3 residents reviewed for behaviors in a sample of 5 (Resident D).	F0250	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-250	06/11/2011

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	Findings include: The facility "Behavior Log" book for the months of January through March 2011 was reviewed on 5/11/11. There were no behavioral entries listed for Resident D. During an interview on 5/12/11 at 10:05 a.m., the Social Services Director (SSD) indicated she maintained the Behavior Log book, but entries were to be completed by all nursing staff, including Certified Nursing Aides (CNA). The SSD indicated she had asked CNA # 1 to complete the Behavior Log book in regard to the reported incident in which Resident D grabbed her inappropriately. The SSD indicated CNA # 1 did not complete documentation in the behavior log, as was requested. She explained CNA # 1 had reported to her that sometimes Resident D would get "excited," meaning an erection would occur, during his showers or personal care. CNA #1 also indicated that Resident D had grabbed her in the (female private) area, but it had been the first time he had displayed that behavior. The SSD indicated the behavioral incident for Resident D was discussed in the Manager's morning meeting on 3/11/11. The managers decided Resident D's		Provision of Medically Related Social Service(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:Resident #D has shown no further inappropriate behaviors. The facility updated Resident D's care plan for inappropriate behaviors. The Director of Social Services was re-educated on the facility standards for timely and proper documentation and care planning of those residents with inappropriate behaviors Facility nursing staff were reeducated regarding documentation of behaviors timely per facility standard. .**(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** Current residents were reviewed for any inappropriate behaviors displayed to ensure care plans and documentation are completed.**(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** The Director of Social Services will be re-educated on the facility standards for timely and proper documentation and care planning of those residents with inappropriate behaviors Facility nursing staff were reeducated regarding documentation of	

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	permission would be obtained to change his shower times. The situation was discussed and it was agreed an evening shower provided by a male CNA would be advisable. The SSD indicated she sometimes spoke to families about resident behaviors, but Resident D's family wasn't notified about his reported behaviors. The SSD indicated she was part of the IDT (interdisciplinary team) and is a participant in the care planning process for the residents residing at the facility. There was no care plan located related to Resident D's sexually inappropriate behavior. She indicated the MDS coordinator (minimum data set of assessments for guiding a resident's care) was the person responsible for care plan updates. The MDS coordinator was not available for interview. The SSD indicated the grabbing incident of Resident D would be considered abusive behavior as she stated, "Yes I would, if it had happened to me." This federal tag is related to Complaint IN00089659. 3.1-34(a)		behaviors timely per facility standard. Residents identified with inappropriate behaviors will be reviewed at the Standards of Care Meeting weekly by the Director of Social Service to ensure the resident's behaviors have been documented timely and a care plan in place for addressing those behaviors. The Facility Management Team will review any resident grievances, concerns, events and any other issues during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any resident , family, or staff concerns in a timely manner. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Social Services or designee will randomly review 5 residents medical records weekly x 4 weeks, then monthly for 2 additional months to determine if any resident behaviors are documented and care planned timely.The Facility Risk Manager will report results at the next QA/Risk Management meeting and monthly thereafter until substantial compliance has been achieved and then quarterly monitoring to maintain compliance **(e) Date of compliance: ___6/11/11_____**	

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on observation, interview, and record review, the facility failed to complete assessments which would accurately recognize and provide treatment for inappropriate sexual behavior for 1 or 3 residents reviewed for behaviors, in a sample of 5 (Resident D).	F0272	Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.	06/11/2011

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	Findings include: Review of a facility policy, dated 2005 and revised April 2007, titled "Problematic Behavior Management - Clinical Protocol," provided by the Director of Nursing (DON) on 5/11/11 at 3:45 p.m., included, but was not limited to, the following: "...Nursing staff will document the nature, duration, and associated features of any changes over time in behavior, cognition, or mood...In addition, the nurse shall assess and document/report the following:..d. Whether resident is a danger to themselves or others....e. Onset, duration, severity of current symptoms...o. Full description of behavior compared to usual behavior...If the resident is being treated for problematic behavior or mood, the staff and physician will seek and document objective reassessments of positive or negative changes in the individual's behavior, mood, and function...." A facility policy, dated February 2004, titled "Standards & Guidelines: Incident Reporting and Documentation," provided by the DON on 5/11/11 at 3:45 p.m., included, but was not limited to, the following:		**F-272 Comprehensive Assessment** (A) What corrective action will be accomplished for those residents found to have been affected by this practice:Resident D was assessed for Behavioral concerns and the Behavior Log was updated. (B)How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken:A comprehensive audit was conducted of active residents with Behavioral issues to ensure behaviors were appropriately documented on the Behavior log. **(C)What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur:** Staff to be educated regarding Problematic Behavior Management and related policy and procedures by DNS or designee (D)How will the corrective action(s) be monitored to ensure the practice will not recur, what quality measures will be put into place:The DNS and/or designee will randomly audit at least 5 residents medical records weekly for 4 weeks and monthly for 2 months to ensure residents	

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	"...The licensed nurse will conduct a full physical and/or mental assessment on any resident related to any incident. The nurse will document in the medical record their findings including any comments made by the resident...." The clinical record review for Resident D was reviewed on 5/11/11 at 4:00 p.m. The record noted diagnoses for Resident D included, but were not limited to: Alzheimer's disease, dementia with behavior, psychosis, delirium, anxiety, and alcohol abuse." The facility "Behavior Log" book for the months of January through March 2011 was reviewed on 5/11/11. The log indicated no behavioral entries were listed for Resident D. During an interview on 5/12/11 at 10:05 a.m., the Social Services Director (SSD) indicated the Behavior Log book was maintained by her, but entries were to be completed by all nursing staff, including Certified Nursing Aides (CNA). A separate "Behavior/Intervention Log", located in the Medical Administration Record, was reviewed on 5/12/11 for the months of March through May. The record contained no entries for any observed behaviors for March, April, or		behavioral issues are documented on the Behavior Log and present in the residents medical record. Findings of these audits will be reported at the facility's monthly Risk Management/QA Committee meeting to determine that compliance has been achieved and quarterly monitoring is recommended. **(E) Date of compliance:** 6-11-11	

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	the current date of May 12, 2011. During observation on 5/12/11 at 6:05 p.m., Resident D was in his room sitting in his armchair while chewing tobacco. The resident indicated that he was satisfied with the amount of showers and care provided by the staff. During an interview with the DON on 5/11/11 at 11:25 a.m., she indicated Resident D had verbalized sexually inappropriate comments to some CNA's, "It was usually new CNA's. He would like to test their boundaries and see what he could get by with." The DON indicated when CNA's came to her with information about those type of behaviors, no incident reports were completed. She stated, "I told them to put it on the Behavior Log - whether they did or not, that's another story." The DON indicated there had been one occurrence of physical, sexually inappropriate behavior with CNA # 1. At 4:54 p.m. the same day, the DON indicated the grabbing of CNA # 1 in the shower was new behavior for Resident D. She said the resident's behaviors were always directed at staff, not residents, and the reported grabbing incident of CNA #1 was the first time he had been physical. During an interview with CNA # 1 on 5/11/11 at 12:35 p.m., she indicated			

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	Resident D acted inappropriately while she was giving him a shower. "He grabbed my crotch in the shower." She indicated this occurred while she was by herself and getting the resident dressed. She stated that at first she thought it might be an accident, but then the resident said to her, "Haven't you ever had a guy cop a feel before?" She indicated she knew then that he understood what he had done. She stated, "My first instinct was to haul off and - but I know we can't do that." She then indicated Resident D said to her, "Well a hot thing like you should be happy a guy like me can get a b----..." She stated she had excused herself and reported the incident to the DON. CNA # 1 indicated she wanted Resident D to be sent out for psychiatric treatment or to file charges against him. She stated, "My thoughts are if he's done it to me, who is he going to do it to next?" CNA # 1 indicated she was told by administration that she could not file charges against him because he was in a nursing home. An interview with CNA # 3 on 5/11/11 at 1:25 p.m., indicated Resident D had been verbally-sexually inappropriate during shower care, but it only happened once and she reported the behavior to the charge nurse and also had documented in the Behavior Log.			

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	A second interview with CNA # 1, on 5/12/11 at 12:12 p.m., indicated she may have not charted the incident in the Behavior Log but confirmed the incident occurred in March of 2011, at which time it had been reported it to the DON. During an interview with Licensed Practical Nurse (LPN) # 9 on 5/12/11 at 12:35 p.m., she indicated she first started at the facility in 12/2010. She indicated while she was new, Resident D made verbalizations of sexual content in reference to her genitalia. She had been administering his medication at that time and she reported the incident to the DON. During an interview on 5/12/11 at 2:15 p.m., CNA # 10 indicated he had provided shower care to Resident D for the past couple of months. The CNA said he only works 3 to 4 days a week, but there were other female staff who provided showers to Resident D on the evenings that he did not work. CNA # 10 indicated during Resident D's shower care, the resident had made reference to the sexually inappropriate behavior with the female staff and said he "...just got a little touch and that's it." The Administrator, during an interview on 5/12/11 at 12:50 p.m., confirmed the lack of behavioral occurrences documented in			

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	the Behavior Log book. She indicated documentation of observed behavioral incidents should be one of the first things to happen with those observations. This federal tag is related to Complaint IN00089659. 3.1-31(a) 3.1-31(c)(7)			
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to ensure a care plan was initiated, interventions provided, and behaviors monitored for a resident who displayed inappropriate sexual behavior for 1 of 3 residents reviewed for behaviors, in a sample of 5 (Resident D).	F0279	Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely	06/11/2011

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	155464	A. BUILDING 00 B. WING	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKVILLE NURSING AND REHABILITATION CENTER	768 NORTH US HIGHWAY 41 ROCKVILLE, IN47872

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	Findings include: The clinical record review for Resident D was reviewed on 5/11/11 at 4:00 p.m. The record indicated the following diagnoses for Resident D included, but were not limited to: Alzheimer's disease, dementia with behavior, psychosis, delirium, anxiety, alcohol abuse..." During an interviewn with CNA # 1 on 5/11/11 at 12:35 p.m., she indicated Resident D acted inappropriately while she was giving him a shower. "He grabbed my crotch in the shower." She said the behavior occurred while she was by herself and getting the resident dressed. At first she thought it might be an accident, but then the resident said to her, "Haven't you ever had a guy cop a feel before?" She indicated she knew then that he understood what he had done. She stated, "My first instinct was to haul off and - but I know we can't do that." She indicated Resident D said to her, "Well a hot thing like you should be happy a guy like me can get a b----." She stated she excused herself and reported the incident to the DON. CNA # 1 indicated she wanted Resident D to be sent out for psychiatric treatment or to file charges against him. She stated, "My thoughts are, if he's done it to me, who is he going to do		because it is required. F279 Comprehensive Care Plans A. What corrective action will be accomplished for those residents found to have been affected by this practice: A care plan for Resident D addressing behavioral issues was immediately developed and implemented.B. How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken: A comprehensive audit of all active residents' medical record was conducted to identify those residents with Behavioral issues and ensure they were appropriately care planned.**C. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur:** An in-service was conducted for the interdisciplinary team using Chapter 4 of the RAI manual as it pertains to development of a plan of care, to review procedures for developing a comprehensive care plan, including resident specific, individualized interventions and possible side effects of medications. D. How will the corrective action(s) be monitored to ensure the practice will not recur, what quality measures will be put into place: The Director of Nursing or Designee will monitor corrective actions to ensure the effectiveness of these actions, including: · Randomly audit at	

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	it to next?" CNA # 1 indicated she was told by administration that she could not file charges against him because he was in a nursing home. Additional staff interviews were conducted related to Resident D's inappropriate behavior. They are as follows: CNA # 3 was interviewed on 5/11/11 at 1:25 p.m. She indicated Resident D had been verbally sexually inappropriate during shower care, but it only happened once. She reported the incident to the charge nurse and documented the behavior in the Behavior Log book. Licensed Practical Nurse (LPN) # 9 was interviewed on 5/12/11 at 12:35 p.m. She indicated she had started at the facility 12/2010. She indicated Resident D had been sexually inappropriate to her when he made comments in reference to her genitalia. She indicated the incident happened during medication administration and she reported the incident to the DON. A quarterly Minimum Data Set (MDS-an assessment tool that is used to guide a resident's care), dated 3/9/11, indicated Resident D required extensive assistance of one person for bathing and the only		least 5 resident's comprehensive care plans weekly for 4 weeks and then monthly for 2 months to ensure the care plan accurately reflects Behavioral issues. · Findings will be reported at the monthly QA/Risk Management meeting until substantial compliance is achieved and quarterly monitoring is recommended. Date of Compliance: 6-11-11	

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	behavior indicated was rejection of care. A behavioral health care plan, with an original date of 9/17/10 and a goal date of 6/14/11, included "resists care" as a behavior problem, but did not include "sexually inappropriate" as a behavior problem. During an interview with the DON on 5/11/11 at 4:05 p.m., she indicated the only intervention put in place to address the sexually inappropriate behavior of Resident D was the rearrangement of the shower schedule, so that showers would be given by the male CNA. During an interview with the Administrator on 5/11/11 at 4:24 p.m., she indicated the sexually inappropriate incident that had occurred in the shower room with Resident D on 3/10/11 was discussed at the morning meeting on 3/11/11. She indicated the Social Services Director had spoken to Resident D about the incident. She indicated interventions from the morning meeting were not documented, but it was decided Resident D would not receive shower care from female staff, unless the female staff agreed and there had been no occurrences of sexually inappropriate behavior by Resident D with the female staff. She indicated there should have been a care			

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	plan in place for Resident D's sexually inappropriate behavior. No behavioral care plan for sexually inappropriate behavior with interventions of care, was located or provided by the facility. This federal tag is related to Complaint IN00089659. 3.1-35(a)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure complete documentation of sexually inappropriate behavior by a resident was located in the clinical record for 1 of 3 residents reviewed for behavioral documentation, in a sample of 5 (Resident D). Findings include:	F0514	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 514 Clinical Records (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:	06/11/2011

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	During an interview with the SSD (Social Services Director) on 5/12/11 at 10:05 a.m., the SSD said she had been told by staff that Resident D had a history of inappropriate sexual comments toward the CNA's, mainly in the shower room or during personal care. She indicated CNA # 1 had reported to her a behavioral incident involving Resident D, that occurred on 3/10/11. The SSD had recorded the incident in her personal notebook, but not the clinical record. She retrieved her personal notebook, which contained, but was not limited to, the following documentation: "...3/11/11 8 a.m. Writer notified by CNA of inappropriate touching during shower by res(resident). CNA very uncomfortable. Writer requested CNA document in behavior book....Writer approached res while he was sitting in chair in his room. Writer asked res, 'Do you remember taking a shower yesterday?' Res said 'Yes.' Writer asked, 'Did you touch CNA (name) inappropriately?' Res stated, 'Yes. Why shouldn't I?' 'I believe that a man can touch a woman whenever he wants.' Writer explained that we can't touch others there and he got agitated with me and said, 'I'm a man I can do whatever I damn want.' Writer explained again why touching was inappropriate and res started shaking his fist and yelling, 'Get the hell		SSD was re educated per teachable moment for standard and guideline for documentation of behaviors. Resident D clinical record has been updated with documentation to reflect the inappropriate sexual behavior, including MD/Family notification. . **(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:** . An audit was conducted of residents with inappropriate sexual behaviors with no other residents identified. **(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:** Staff will be re-educated on standards and guidelines for documentation and behavior management of inappropriate sexual behavior, and professional standards of practices for maintaining clinical record documentation. **(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:** DNS/Designee will review the 24 report during stand up meetings to identify any resident experiencing unusual or sexual behavior for the next four weeks then twice a month X 2 months. Any issues identified will result in review of the Residents clinical	

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	outta here.' Writer asked if res would like to switch his shower day to the evening with a male CNA and he said, 'I don't care just get the hell outta my room.' Writer left and reported to DON (Director of Nursing) and charge nurse explaining situation, change of shower time/day. Staff agreed that our male CNA (name) would shower res. from now on." The clinical record review for Resident D was reviewed on 5/11/11 at 4:00 p.m. The record noted diagnoses for Resident D included, but were not limited to: Alzheimer's disease, dementia with behavior, psychosis, delirium, anxiety, and alcohol abuse." There was no complete documentation located in the IDT (Interdisciplinary Team) notes, or clinical record for Resident D, or provided by the facility, which addressed the resident's sexually inappropriate behavior. This Federal tag is related to Complaint IN00089659. 3.1-50(a)(1)		record for appropriate documentation including MD/Family notification. The above audits will be reviewed at the next Risk Management/QA committee meeting to determine if compliance has been met and recommended that monitoring will be quarterly by the RDCO when she completes her system reviews which includes behavior monitoring and documentation. (e) **Date of compliance**: 6/11/11	